Patient Intake Form — Waldrop Chiropractic Clinic

1. About You

Print Name: ____ Birth Date: ____/____/_____ Todays Date:____/_____/______

What do you preferred to be called: _______________________ □ Male □ Female Age: __________________

Mailing Address: _______________________________________ City ______________ St: ___________ Zip ______________

Home #________________ Work#___________________ Cell#______________ Email: _______________________________

Referred By: ________________________________ Employer: ____________________ Occupation: ____________________

Status: □ Minor □ Single □ Married □ Divorced □ Separated □ Widowed

Spouses Name: __________________________Children: □ Yes □ No How Many: ____

Emergency Contact Information: Who should we contact: _________________________________

Relation: _____________________________________ Phone #: _________________________

Who is your Medical Doctor: ________________________________ M.D.'s Phone #: _____________________________

2. Reason For Your Visit

Reason for Today's Visit: □ Backpain □ Neck pain □ Headache □ Other ___________________________

Describe ____

Did your injury occur during: □ Work □ Sports □ Auto Accident □ Household Activity?

When did you accident occur? ____/_____/_____ Where did your injury occur: _________________________________

Is your condition getting worse? □ Yes □ No □ Constant □ Comes and Goes

Is your condition interfering with your: □ Work □ Sleep □ Daily Routine □ Other

If so, how: ____

Has this or something similar happen in the past: □ Yes □ No

If Yes, Explain: ____

Have You Been Treated For This Condition Previously □ Yes □ No If Yes, Where: _________________________________

Have you ever been treated by a Chiropractor: □ Yes □ No If Yes, Where: _________________________________

What makes the problem better? ____

What makes the problem worse? □ Sitting □ Standing □ Lying □ Movement □ Rest
□ Use □ Walking □ Running □ Working □ Activity
□ Bending □ Lifting □ Twisting □ Other __________________

Describe the pain or sensation? □ Achy □ Burning □ Dull □ Numb □ Sharp
□ Shooting □ Sore □ Stabbing □ Stiff □ Tingling

Does the pain radiate to any other area of the body? □ Yes □ No If Yes, Where: _________________________________

How Frequent is the problem? □ Constant □ Frequent □ Intermittent □ Occasional □ On/Off
□ Evening Only □ Morning Only □ Stabbing Worse in the: □ AM □ PM

Activities of Daily Living Affected:

General: □ Arising from seated position □ Bending □ Chewing □ Climbing Stairs □ Exercising
□ Getting in/out of vehicle □ Kneeling □ Lifting Children □Lying in Bed □ Reading
□ Running □ Sitting □ Sleeping □ Standing □ Swimming □ Using Computer
□ Using Phone □ Other _____________________

House Work: □ Caring for Pets □ Carrying Groceries □ Cleaning House □ Cooking
□ Doing Laundry □ Ironing □ Making Beds □ Washing Dishes Grooming:
□ Brushing Teeth □ Combing Hair □ In/Out Bathtub □ Shaving

Travel: □ Driving □ Riding (passenger) □ Rotating Neck

Yardwork: □ Gardening □ Mowing Lawn □ Raking Leaves

3. Review of Systems and History

Check or Circle the appropriate response, please leave blank if it does not apply.

Past Medical and/or Family History

P= Patient M= Mother
F= Father S= Sibling

- □ Heart Disease P M F S
- □ Asthma P M F S
- □ Cancer P M F S
- □ Arthritis P M F S
- □ Headaches P M F S
- □ Diabetes P M F S
- □ MVP P M F S
- □ Emphysema P M F S
- □ Anemia P M F S
- □ Fibromyalgia P M F S
- □ Hernia P M F S
- □ High BP P M F S
- □ Low BP P M F S
- □ Alzheimer's P M F S
- □ Alcoholism P M F S
- □ Colitis P M F S
- □ Epilepsy P M F S
- □ Goiter P M F S
- □ Gout P M F S
- □ High Cholesterol P M F S
- □ Kidney Disease P M F S
- □ Leukemia P M F S
- □ Lupus P M F S
- □ Mental Condition P M F S
- □ Obesity P M F S
- □ Rheumatoid Arthritis P M F S
- □ Ulcers P M F S
- □ Injuries P M F S
- □ Trauma Auto/etc. P M F S
- □ Other ____________________ P M F S

Social History

Caffeine □ No □ Light □ Heavy
Tobacco □ No □ Yes
Packs Per Day_________________
Alcohol □ No □ Yes
Per Day/ Week________________

Surgical History

□ Appendectomy □ Hemorrhoid
□ Gall Bladder □ Tonsillectomy
□ Thyroidectomy □ Kidney Stone
□ Bladder □ Endoscopy
□ Angioplasty □ Heart Bypass
□ Back Surgery □ Neck Surgery
□ Arthroscopic________________
□ Joint Replacement ___________
□ Mastectomy □ Breast Implant
□ Tubalitigation □ C- Section
□ Endometriosis □ Hysterectomy
□ Other _____________________
□ Other _____________________

Exercise

□ Frequently □ Occasionally
□ Never Frequency___________

Review of Systems

Please circle if you have had and of the following:
(P = Past, 1 = Mild, 2 = Moderate, 3 = Severe)

General Health

P 1 2 3 Fatigue/ Tiredness
P 1 2 3 Fever/ Night Sweats
P 1 2 3 Trouble Sleeping
P 1 2 3 Skin Irritation / Rash
P 1 2 3 Bleeding Disorder
P 1 2 3 Depression
P 1 2 3 Anxiety/ Tension

EENT

P 1 2 3 Vision/ Eye
P 1 2 3 Hearing/ Ear
P 1 2 3 Throat/ Swallowing
P 1 2 3 Nasal/ Sinus
P 1 2 3 Headaches/ Face Pain

Cardiopulmonary

P 1 2 3 Breathing
P 1 2 3 Swelling/ Edema
P 1 2 3 Chest Pain

Gastrointestinal

P 1 2 3 Stomach/ Abdominal
P 1 2 3 Diarrhea/ Constipation
P 1 2 3 Vomiting

Genitourinary

P 1 2 3 Urinary Frequency
P 1 2 3 Urinary Burning
P 1 2 3 Sexual/ Reproductive

Skeletal

P 1 2 3 Morning Stiffness
P 1 2 3 Night Pain
P 1 2 3 Neck Pain
P 1 2 3 Back Pain
P 1 2 3 Joint Pain_____________
□ Fracture ___________________

Neuromuscular

P 1 2 3 Muscle Pain
P 1 2 3 Weakness
P 1 2 3 Numbness/ Tingling
P 1 2 3 Tremors/ Shakes
P 1 2 3 Loss of Consciousness
P 1 2 3 Passing Out

Females

Pregnant: □No □ Yes
□ I Don't' Know
Breast Feeding □No □ Yes
Last Menstrual Cycle ___________

Males

□ Prostate Problems

Present Medication

□ None □ List________________
____
____
____
____

Allergies

□ Penicillin □ Codeine
□ Aspirin □ Sulfa
□ Other ____________________
□ Other ____________________

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_______________________________________ **Date** _____/_____/_____ □ Patient □ Guardian □ Spouse